Women's Healthcare of Illinois

9730 South Western Ave., Ste. 100
Evergreen Park, IL 60805
Phone (708) 425-1907 ♦ FAX (708) 422-4253

10260 W. 191st St., Ste. 100
Mokena, IL 60448
Phone (708) 425-1907 ♦ FAX (708) 422-4253

Medical Records Release Authorization

I, _____ hereby authorize **Women's Healthcare of Illinois** to release the following information on:

Patient name: _____ Birth date: _____

Patient address: _____

Phone number: _____

Please check all information to be released: (*Allow a minimum of 5 business days for copying*)

- □ Entire record set
- □ Registration record
- □ Laboratory reports
- □ Imaging reports (ultrasound/mammogram)
- □ Problem list
- □ Medication list
- □ Physician notes
- □ Other _____

Dates of treatment: _____

Information shall be released (sent) to: _____

Address: _____ Fax: _____

Phone number: _____

Purpose for release of records:

□ 2nd Opinion/consult □ Moving □ Changing physicians □ For attorney □ Personal use

Other: _____

1) *I understand that my records may include reference to sexually transmitted disease, alcohol or drug use and/or AIDS or HIV status, if applicable. It may also include information about behavioral or mental health status.* □ ***Include these records*** □ ***Do not include these records***
2) *I understand that I may revoke this authorization at any time in writing, otherwise this consent will be considered valid for sixty (60) days.*

Fees:

I understand that the State of Illinois Code of Civil Procedure 735 ILCS 5/8-2001(d) authorizes medical providers to charge a fee for record copying. I understand that the fee may include a handling charge *(effective 2015)* of $26.58 plus up to $1.00 per page for the first 25 pages, $.66 per page for 26-50 pages, and $.33 per page thereafter plus the cost of postage. We require payment before records are released. Federal privacy rules require that requests for copies of health records must be responded to no later than 30 days after receipt of the written request. If we are unable to meet your request to copy records within 30 days we will notify you in writing.

I authorize the following individuals to pick up my records:_____
(must bring picture ID)

Authorized signature: _____ Date: _____

Relationship to patient: □ Patient □ Legal guardian □ Parent □ Healthcare power of attorney
(submit signed copy)

Staff Initials _____